Formulation when working with trauma in forensic settings: collaboratively making sense of states, contexts and culture in complex populations

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What I am going to talk about

- Problems to avoid
- Collaboration
- Formulation of what?
- Motivational systems (not just the threat system)
- Altered consciousness
- Sequences
- Context
- Culture power and mortality
- Sequences
- Repertory grids
- Final thoughts

“Trauma-Informed Care” Left Me More Traumatised Than Ever

https://www.psychiatryisdrivingmemad.co.uk/post/trauma-informed-care-left-me-more-traumatised-than-ever

“Over the years, as I shared more and more of my traumatic experiences, more and more of me was erased. I couldn't move or breathe without being told I was doing so because of my trauma. It hurt, to be so completely defined by the most terrible moments of my life, especially when my attributes, the things I was proud of; my drive, my passion for justice, my loyalty, my compassion, were also considered traumatic instalments. As if the people who took so much from me, who I had fought to be free of, had actually created me. I got stuck on this in therapy. I was merely a product of abuse, nothing was attributable to *me*, even my good parts were theirs. My strengths, my quirks, my unique ways of being were just my reactions to trauma”.

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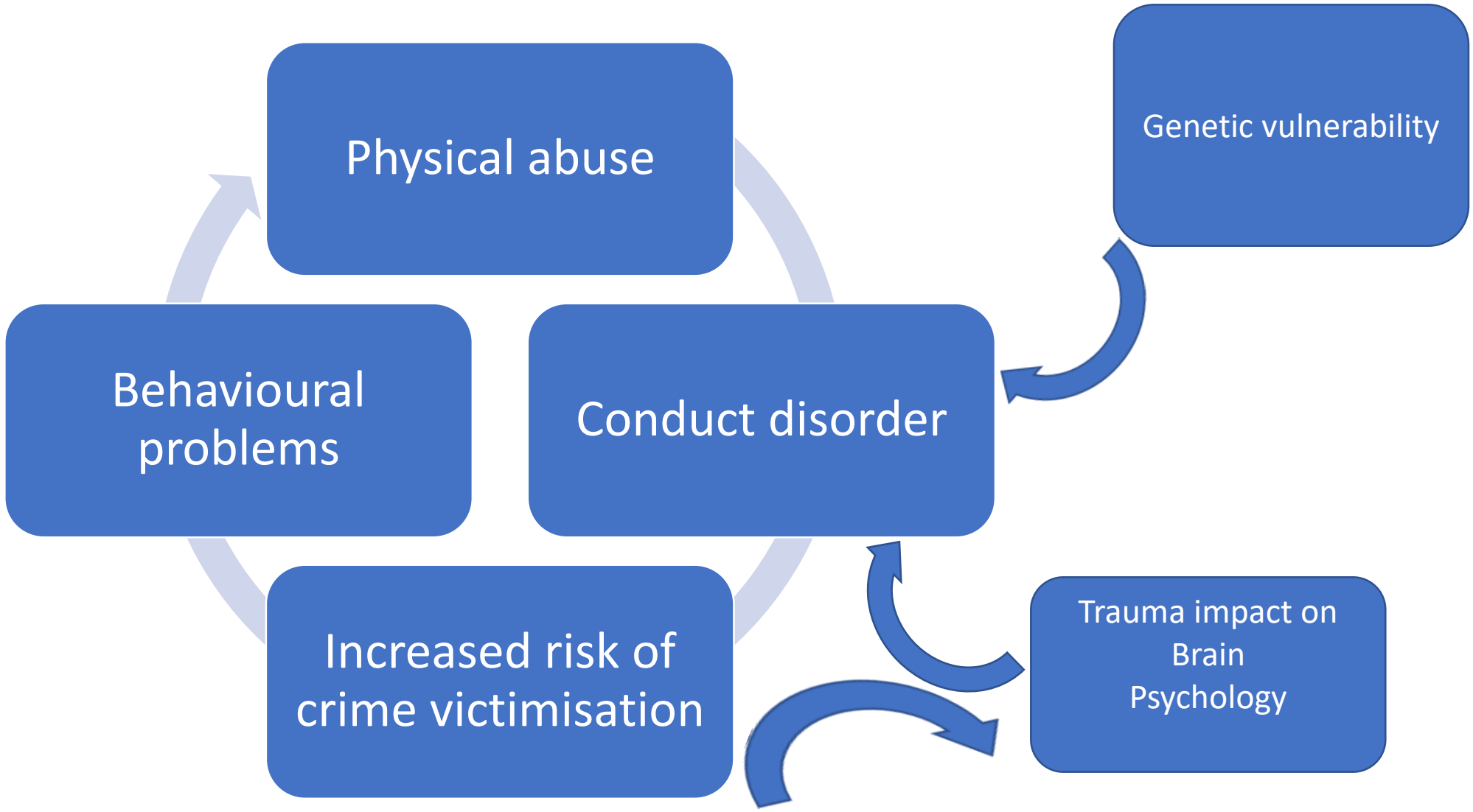
Psychopathy (Perry & Lee 2020)



Neglect of the complex: Why psychotherapy for post-traumatic clinical presentations is often ineffective, Corrigan, F.M. and A.M. Hull, Psychiatrist, 2015. **39**(2): p. 86-89.

"Evidence of efficacy in studies of post-traumatic conditions is largely derived from studies in which variables are kept to a minimum.

Extrapolation of treatments from uncomplicated disorders to complex conditions may therefore be called evidence-based without being evidenced. Complex conditions with polysymptomatic presentations and extensive comorbidity are being denied proper evaluation, and patients most severely traumatised from the early stages of their development are not provided with rigorously evaluated psychotherapies because they are more difficult to study in the manner approved by research protocols. Such evidence as there is suggests that the simple extension of treatments for uncomplicated disorders is seriously inadequate. This has significant implications for health services responsible for the provision of the most efficacious treatments to those whose disorders arise from severe trauma, often very early in their life"

Formulation Emotions

- Curiosity
- Confirmation bias – the feeling of thinking you are ‘right’
- Relationships with theories (attachment to our models)
- The urge to shoehorn – implicit one size fits all
- Telling people what they are really thinking/feeling/experiencing (the magistral stance) as an experience of power (e.g. interpretations)
- Co-curiosity
- Getting stuck in the generating hypotheses stage of problem solving because it is exciting, but might get in the way of moving into solutions and interventions stage
- Need to have an internal supervision space where you keep an eye on the therapeutic relationship; formulating what is happening in your mind, the mind of the other person and in the relationship
- Internal supervision…fluid formulation in the moment

What do service users want from formulation?

- Normalisation – I'm not alone, others have experienced this
- Understanding as an antidote to self-blame
- 'What I did to survive' as a way of framing formulations
- Want to be involved and listened to
- Don't want to feel 'shoe-horned' (thematic review of case formulations suggested that there was a possible 'implicit one size fits all' … all had 'mistrust abuse schema' … at that time none had a neuro component to the formulation)
- Sometimes want to focus on maintaining processes rather than longitudinal (Spencer et al 2022), but can experience this as self-blaming
- Need to acknowledge injustice (usually a litany of unconvicted offences they have been a victim of) and context – external locus of distress and harm is real, but passive responses to this can be unproductive. Still, the story needs to be heard and validated
- Power Threat Meaning approach helps with validating threat responses

Disagreements?

- The people we work with have ways of explaining what they have been through and why they have done what they have done
- What happens when what we see doesn't dovetail with what they see?
- Need to take a tentative stance and offer humility
- Formulation of 'denial'…what needs does it meet? ….for some people it is what keeps them alive
- Inhabit the common ground
- Avoid abusive enactments around coercing people into 'owning responsibility'
- Amnesia for offending is common with serious offences
- Loss or felt agency can also be a feature

Thrower et al 2024 Consensus study of key components of a formulation

TABLE 2 Statements that met consensus due to more than 80% of participants rating them as important for the content of a formulation.

Component statements	Round agreement reached	Consensus (*n*, (%))
It's important to include a list of problems the individual is experiencing	2	88 (80)
It is important to include socio-cultural factors (the larger scale forces within cultures and societies that affect the thoughts, feelings and behaviours, such as sexuality, cultural identity and ethnicity)	2	91 (83)
It is important to use language and metaphors specific to the individual	2	102 (93)
It is important to include perpetuating factors	2	101 (92)
It is important to include protective factors	2	97 (88)
It is important that personal meaning for the service user is integrated throughout the formulation, for example what a diagnosis/event means to the individual	2	94 (85)
It should be in accessible language	2	102 (93)
It's important to include physiological effects such as sleep or side effects of medication	2	94 (85)
It's important to include potential organic causes of difficulties, for example, dementia or learning disabilities	2	94 (85)
It's important to include recent historical events	2	89 (81)
It's important to include strategies the individual uses to manage their difficulties (i.e. defensive/compensatory/coping strategies)	2	102 (93)
It's important to include cycles or patterns that maintain the individual's difficulties	2	104 (95)
It's important to include relational interactions	2	92 (84)
It's important to include a list of individual's strengths and achievements	3	41 (80)
It's important to include childhood history and events	3	45 (88)
It's important to include beliefs/internal working models/rules/assumptions/schema	3	45 (88)
It's important to include meaning-making	3	43 (84)
It's important to include people's perceptions of the support they experience	3	41 (80)

Note: Percentage of consensus is presented next to the number of individuals who rated this component as important.

Contexts, levels (Kuyken et al 2011) and focusses of formulation

- Initial hunches
- Hypothesis dredging (using a set of standard psychometrics aimed at a set of pre-established hunches about what might be going on) in standardised assessment strategies
- Engagement formulation (individualised ‘what works’ based on that person's previous responses to intervention, identifying potential pitfalls/obstacles and doing a ‘drop out prevention plan’ …like DBT therapy interfering behaviour analysis. Looking at trauma related processes that lead to non-engagement
- Global formulation of general patterns of relating (e.g. CAT or Schema diagram) useful when working on a collection of problems and with clinical teams
- Analysis of a specific event (e.g. functional analysis looking at an assault)
- Focus on personal distress
- Focus on offending of different kinds specifically or offending propensity generally if they are ‘versatile’ (Willmot, e.g. 2023)

Formulating change processes

- Based on what you know about this person what hypotheses do you have about how they might respond to an intervention targeting change?
- Is there a hypothesised getting ‘worse’ before getting ‘better’ phase?
- How might they respond to this?
  - Might they self-harm?
  - Might they become assaultive?

  If they don’t have destress tolerance skills
- If they have a history of relational trauma, how might they react to forming a therapeutic relationship?
- How might you predict they will respond based on past relational ruptures?
- What change processes has this person shown that they can tolerate and which not in the past?

Empathy formulations

- A formulation of what got in the way of empathy at the time of the offence
  - Dissociation
  - Emotional numbness
  - Futurelessness
  - Mortality beliefs
  - Vengeful feelings associated with trauma
    - Against individuals
    - Or categories of individual

Metacognition, meta-memory and cognitive emotions

- Beliefs about experience; thinking and memory
- self-monitoring, self-representation, and self-regulation processes
- What sense do people make of having intrusive thoughts?
  - Why am I having (intrusive) thoughts about my sexual abuse?
  - I believe that people choose their thoughts
  - Why am I choosing to think these thoughts and have these memories?
  - It must be because I wanted to think about it?
  - Why do I want to think about it?

Conservation of resources theory Layne Briggs and Courtois (2014)

Focussing on context as well as individual

COR qualities of resources	Good Lives interpretation
1. The amount of resources or 'resource reservoir' prior to the stressor(s).	Contextual capacity to deliver and support acquisition of goods in sustained way.
2. The 'Shelf life' of the resource; will it last or lose its usefulness.	Availability of a particular approach to obtaining goods over time.
3. The 'Potency of the resource; how strongly does it offset the harmful effects of the stressor.	The extent to which a particular 'good' meets the need previously met by offending.
4. The 'robustness' of the resource; does this resource impact on a limited number of stressful events or is it effective for a range of different kinds of stressor?	The extent to which acquisition of the good meets a range of needs as opposed to just a few.
5. The 'transportability' of the resource; would the resource still be there if the individual moved to a different location?	Transportability of goods acquisition processes.
6. The 'durability' of the resource; if the resource was used repeatedly for a long time would it still be accessible or would it wear out quickly?	The durability of a particular approach to acquiring 'goods' .
7. The 'replenishability' of the resource; how easily can the resource be replenished if it is depleted?	The extent to which a means of acquiring goods can be replenished if depleted.
8. The 'accessibility' of the resource; is the resource accessible when it is needed?	The ease with which a good can be accessed when it is needed.
9. The 'efficiency' of the resource; does the coping strategy require a high level of effort and resources?	The extent to which a good does not require other resources in order for it to be actualised.
10. The 'facilitative effect' of the resource; how well does the resource facilitate, catalyse or support other resources?	The extent to which acquisition of a good facilitates the acquisition of other significant goods.
11. The 'generative capacity' of the resource; does the resource create new resource (a kind of meta-resource).	The extent to which the obtaining of a good creates new opportunities for needs to be met with other goods.

Protecting Against Adversity: The Role of Positive Childhood Experiences in Youth Recidivism (Kowalski et al 2023)

Presence of PCEs was associated with lower reoffending likelihood, and ACEs were related to increased recidivism odds. Further, PCEs demonstrated a protective impact on ACEs. A ceiling effect on the ACE-PCE composite score was also identified, where an increase in scale items presented a curvilinear recidivism association

The ability to talk with family about feelings.

The sense that family is supportive during difficult times.

The enjoyment of participation in community traditions.

Feeling a sense of belonging in high school.

Feeling supported by friends.

Having at least two non-parent adults who genuinely cared.

Feeling safe and protected by an adult in the home

Trauma Trajectories … like offence and relapse processes …its not just the event or symptoms it's the consequences downstream (Taken from Layne & Hobfoll 2020)

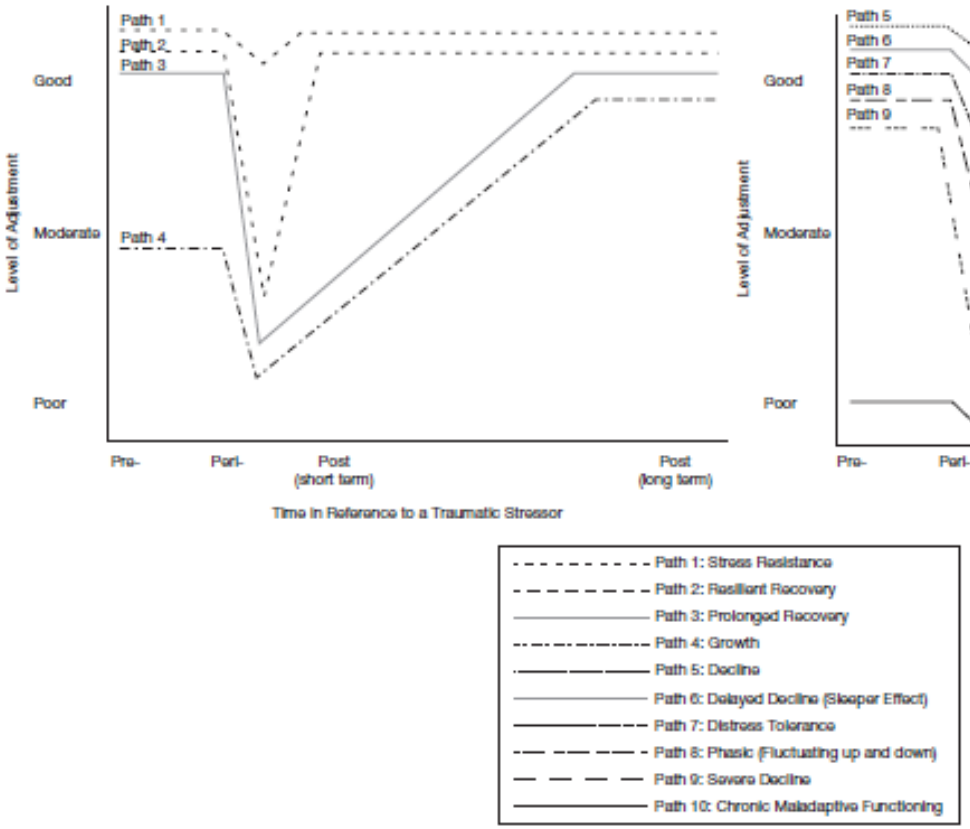


Figure 5.1 Trajectories of positive adjustment.

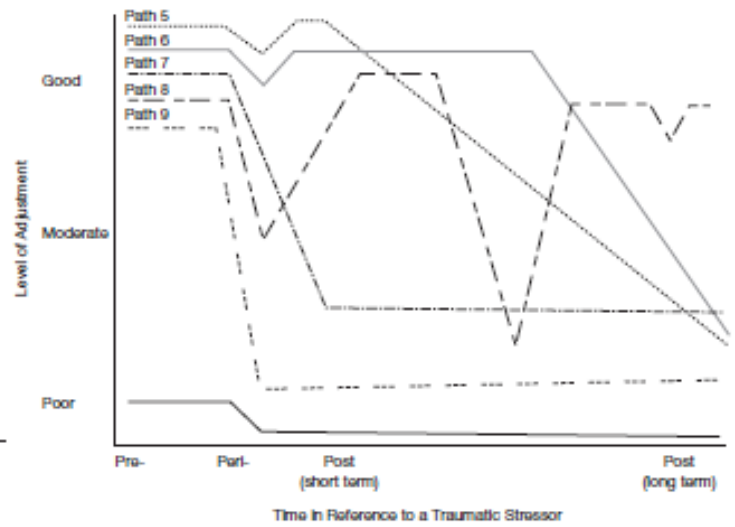


Figure 5.2 Trajectories of poor adjustment.

Trauma Trajectories … like relapse processes. (Taken from Layne & Hobfoll 2020)

Early intervention most effective

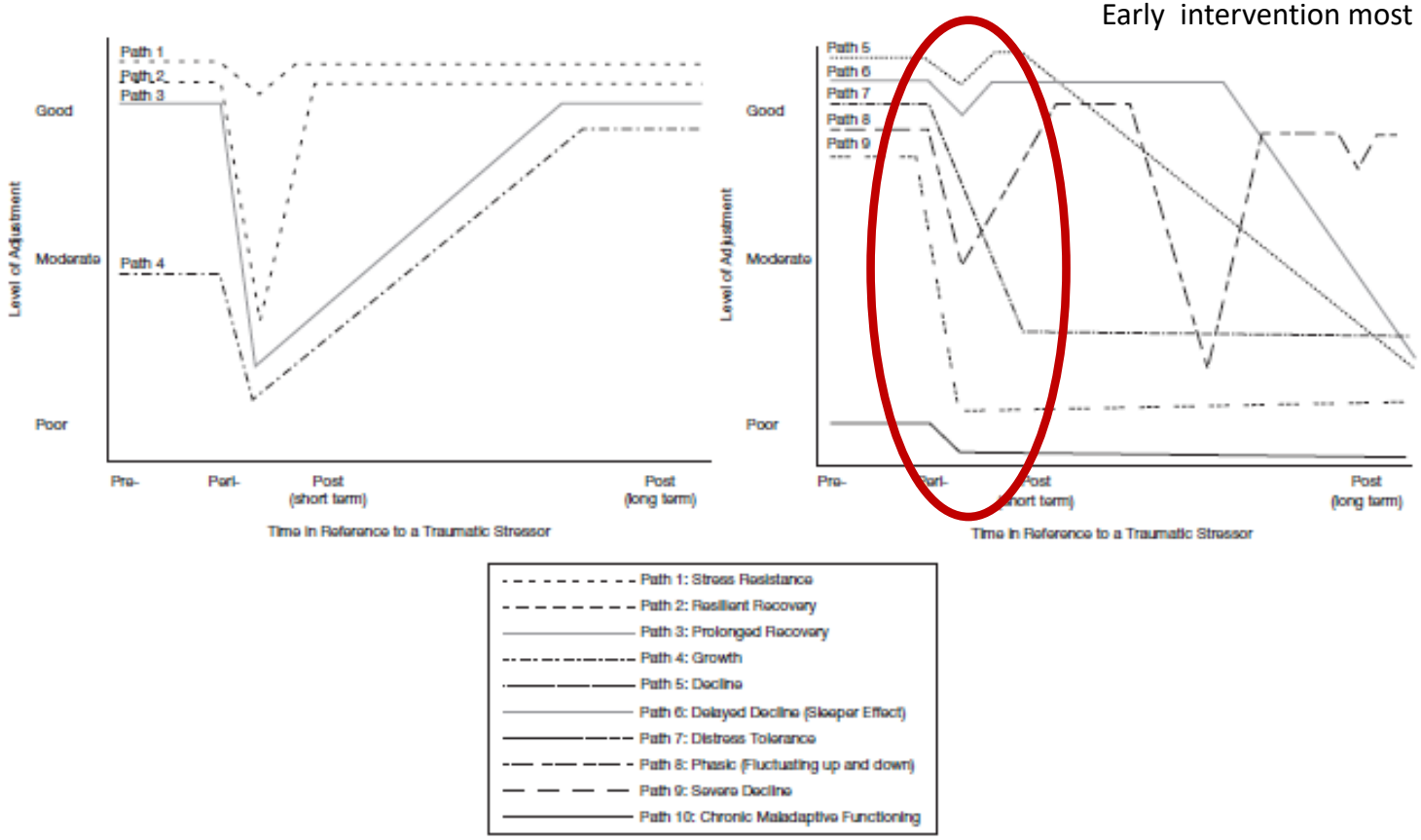
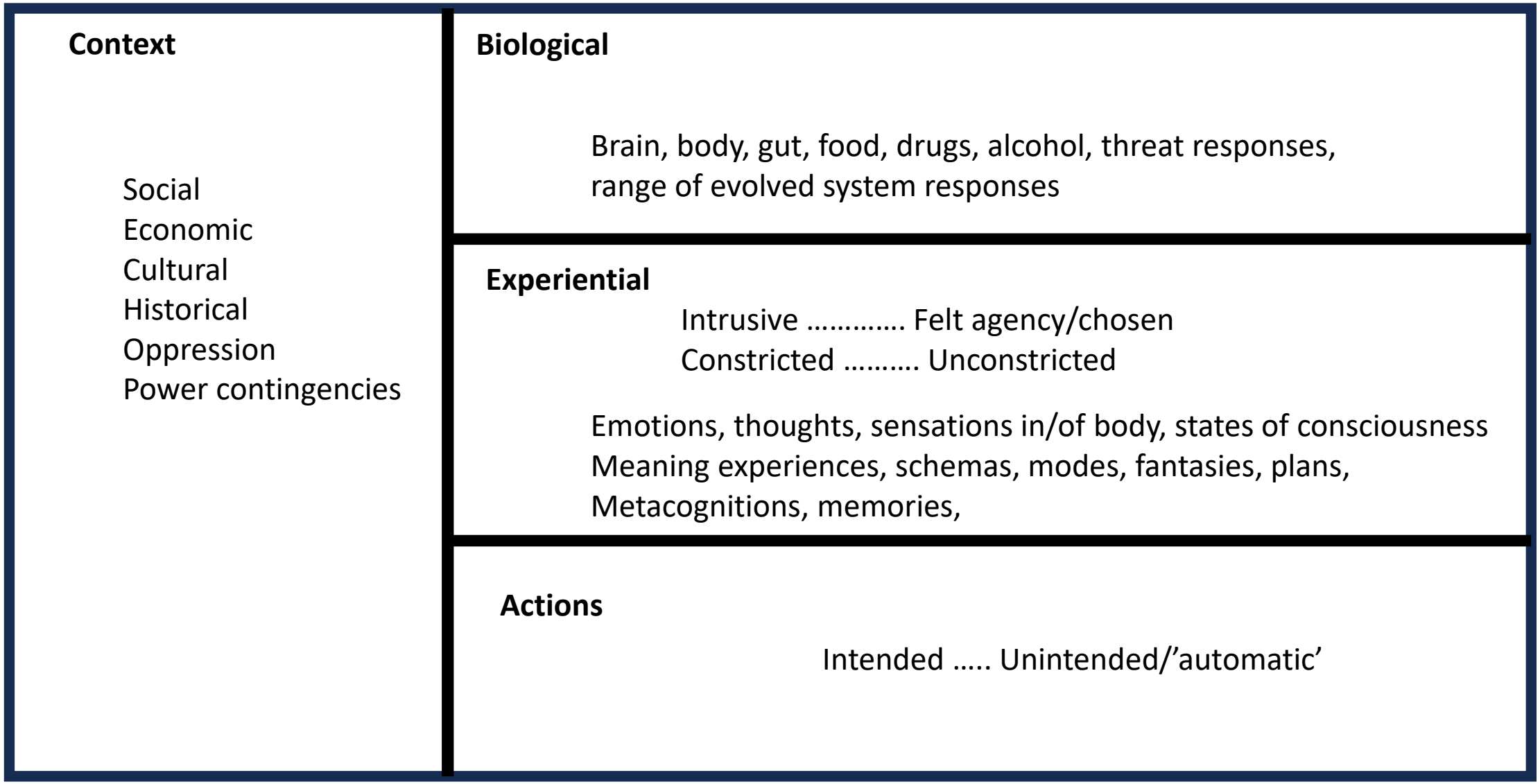


Figure 5.1 Trajectories of positive adjustment.

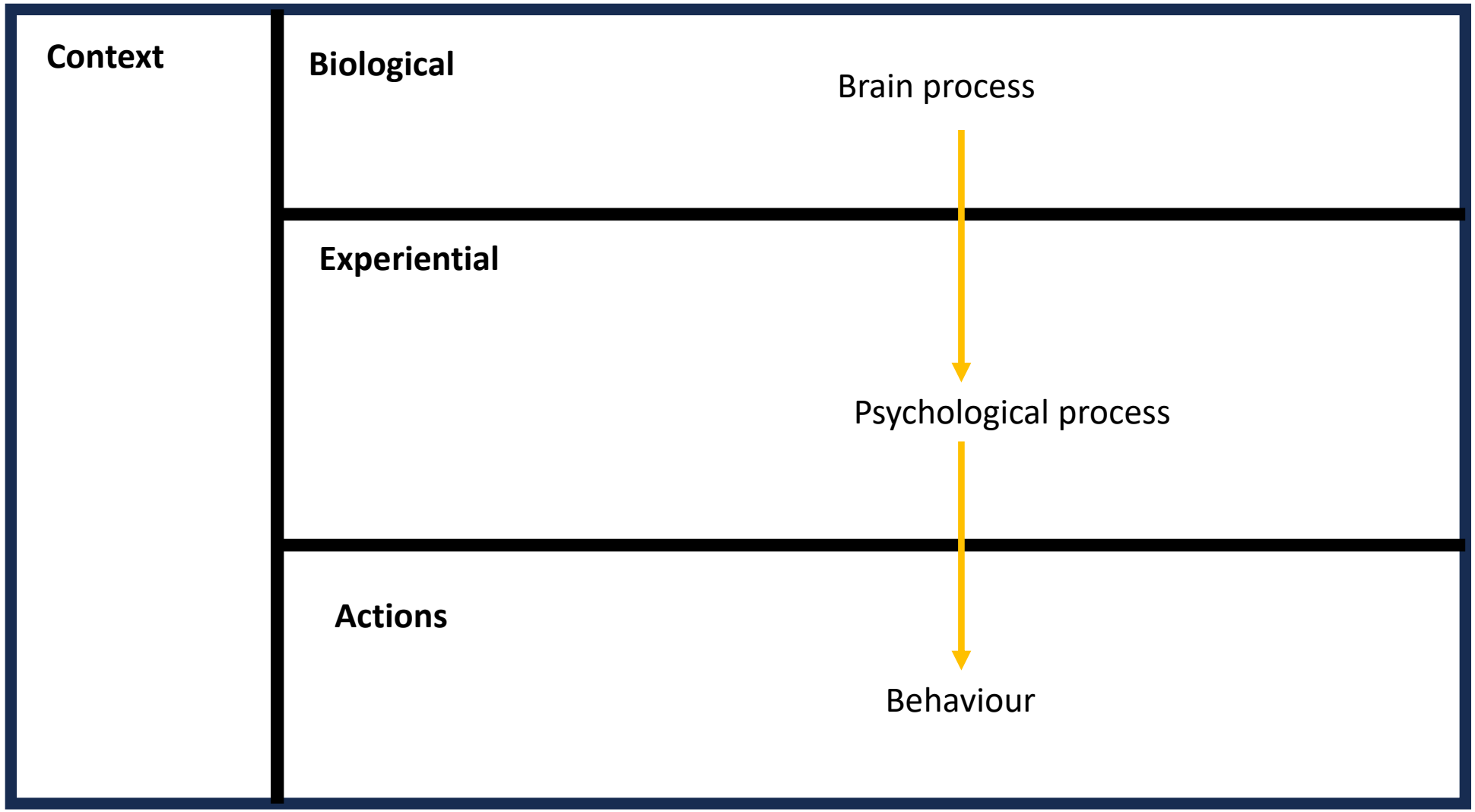
Figure 5.2 Trajectories of poor adjustment.

Formulation as causal modelling: Morton (e.g. 2004) diagrams

- Morton developed a model for describing developmental models of psychological problems in a way that synthesises information from a number of different ways of describing the world
- Used them to contrast competing aetiological theories
  - E.g. is autism 'caused' by experiences or by neuropsychological problems
- A useful model for diagramming some kinds of formulation
- Biopsychosocial model (Engel 1977, Bolton & Gillette 2019) attempts to synthesise information from different epistemologies. Bio is often logical positivist, psycho is constructivist/ social realist, social is sociological, post-modernist ….
- Diagram helps to clarify what it is you are hypothesising
- Great also for communicating about multiple factors interacting
- Critical areas of uncertainty are the processes whereby biological events impact on experiential events, contextual events impact on biological processes and experiential processes
- Also problems with 'multifactorial' approaches with choosing which factors to 'target' with interventions


Context
Social
Economic
Cultural
Historical
Oppression
Power contingencies
Biological
Brain, body, gut, food, drugs, alcohol, threat responses,
range of evolved system responses
Experiential
Intrusive ……. Felt agency/chosen
Constricted ……. Unconstricted
Emotions, thoughts, sensations in/of body, states of consciousness
Meaning experiences, schemas, modes, fantasies, plans,
Metacognitions, memories,
Actions
Intended ….. Unintended/'automatic'

Kinderman (e.g.2005) Usually biological processes' impact on behaviour is mediated by a psychological process
Need to identify what those processes are



Motivational systems (Panksepp 1998, Monticelli & Liotti, 2021, Gilbert e.g. 1998)

	Trauma	Offending
Dominance/status	Neglect, lack of boundaries, turning to dominance to meet safety needs when cant meet them through attachment	Controlling and abusive behaviour, violent and sexual offending, robbery,
Threat/fear	Violent and sexual abuse Neglect Emotional abuse	Violence linked with 'fight' response to threat, flight and freeze can also contribute to offending processes
Sexual	Sexual abuse, violent abuse, neglect	Sexual interests 'vandalised' by sexual abuse
Attachment	Grief, rejection, abandonment, betrayal trauma	Domestic violence, sexual offending, dissociation and betrayal blindness

Working with impact of trauma on evolved systems FAP
(Kuei et al 2019)

Evolutionary Needs	PPEB Functions	Client		
		CRB 1		CRB 2
		Deprivation	Aversive condition	Satiation/Incentive value
Individual Needs				
Basic Functioning	1 - SEEKING (Wanting, incentive value – promotes awareness, checking-in state, are needs met?) Works[1] with[1] 2-9	Stuck in searching, stuck in appetitive repertoire Stuck in sense of scarcity/deprivation, "not enough" instant gratification, low self-control Unresponsive to appetitive stimuli, and satiation passive, helpless, restrict needs-seeking, not aware, dysthymia Behavior insensitive to context	Agitated, restless, Flooded with emotion Hypervigilent Lack of attention, on automatic, unaware of threat Stereotypical behavior Dissociated. Behavior insensitive to context	Aware, curious, creative, open Show satiation/safety by ending seeking behaviour, restore to resting state, cosummatory behavior Able to demonstrate appreciation & gratitude. Behavior congruent to context, Adaptive vigilance
Basic Survival	2 - DISGUST/SHAME (self-loathing, wanting to hide, or judgmental, denigrate others) Works with 2-9	Self-denigration, self-critical Show contempt for deprivation, critical of others/world "not good enough" Ashamed of deprivation, being "not enough" Shame around needs expression or receiving care Hiding, low disclosure, worry about therapist judgment	Denigrate others, with excessive entitlement. Makes therapist feel "not good enough" Critical and negative, grandiose Receiving attention is aversive and evokes shame. Avoid eye contact Body closed up Submissive and allow therapist to dominate	Aware of judgements and shame Willing to talk openly, approach shame and own expression of disgust receive therapist compassion
	3 - ANGER (enforce boundary protection & unmet needs) Works with 4 & 9	Sensitive to deprivation/" unfairness' leading to forceful needs-seeking Blame others for not meeting needs Angry at self for having needs Demanding and controlling through rigid rules. Avoidance: No clear expression of anger when needs thwarted. Submissive with needs-seeking	Sensitive to Feedback or criticism evokes intense anger Body tense. Agitation, aggressive posturing Stuck in fight responses, defensive, vigilant for threat. Oppositional to demands, obstructive Indirect/avoidant expressions of anger. Stonewalling, or shutdown.	Communicate anger, able to describe triggers and unmet needs and take assertive action. Able to connect with vulnerability without defence. Willingness to let go of unmet needs or accept uncontrollable situations. Able to see vulnerability in others with compassion.
	4 - FEAR (Identifying danger, threat, avoid damage, and ensure physical safety. Defence, flight behaviour) Works with 3 & 9	Hoard resources – ie. take more session time, lots of demands on therapist, lots of asks Unentitled to resources, afraid to ask, afraid to take Delayed /non-payment payment issues	Excessive reassurance seeking, Hypervigilent of therapist, nervous agitation Risk averse - Avoid uncertain or unfamiliar situations, rigid with routines Avoidant withdrawal, little eye contact, body closed in Helpless, stuck in freeze response, body stiff and unresponsive	Communicate fears clearly Can reality check fear Ask and reach out for help Accept help
Social Needs				
Reproduction	5 - LUST (sexual attraction and sexuality) Works with 6 & 7	Excessive sexual & seductive behaviour Need physical admiration and evoke sexual attention for attention function Use sexuality to gain needs/resources Lack of care for physical presentation Lack of sexuality, or averse to sexuality	Intimidating sexual assertion for control Violate physical boundary in session Evoke sexual attention for protection function Finds sexual attention/expression from others threatening Avoidant of sexual expression/sensations, or situations with potential sexual connection Finds physical contact or sensory experience threatening	Talking openly about feelings of attraction. Feel comfortable with sexual sensations Can be aware of own sexual pleasure and communicate needs Open and relaxed posture Can discriminate between caring touch from sexual touch. Can set physical boundaries

Working with impact of trauma on evolved systems (Kuei et al 2019)

CRB1= Behaviour that resembles problem
CRB2= Behaviour that meets same need in a more helpful way
CRB3= Insight into CRB1 and CRB2

Evolutionary Needs	PPEB Functions	Client		
		CRB 1		CRB 2
		Deprivation	Aversive condition	Satiation/Incentive value
Group cohesion: Bonding and development	6 – PANIC- attachment (Specific fear related to loss of attachment figure; triggers care-seeking behavior to create bonding) Works with 5 & 7	Excessively preoccupied with own needs, and bodily sensations. Seek intense connection. Verbose and intrusive Demand excessive contact. Worry about ending Low or ineffective care-seeking repertoire Not able to identify needs, dissociated from body Rigid adherence to limited needs-seeking repertoire Insensitive to therapist care taking. Avoid displaying vulnerable expressions that foster closeness.	Panic attack Dependent behaviour, excessive reassurance seeking, frenzied behavior Unable to make decisions, unable to commit to therapy Withdrawal when vulnerable Insensitive to the presence of therapist for safety Physically frozen and tense	Ask for connection and needs fulfilment, Registering connection and calming down Proactive and effective care-seeking repertoire
	7 - CARE (caretaking of others, maternal/paternal or social bonding) Works with 5 & 6	Excessive care-taking of others or self (hypochondria) Hypervigilent of own/ therapist needs Care-taking to function as attachment needs Protect therapist from own needs Difficulty identifying own needs, Poor self-care Insensitive to therapist needs. Low care-taking repertoire for others Hoard own resources by not care-taking others	Deliberate poor self-care to punish self/others Take care of therapist to avoid disapproval/ rejection. Become therapist' s carer for control/safety Excessive independence when problem solving. Evoke vulnerability in others to take care of Submissive care-taking role to avoid conflict Avoid noticing and responding to others' needs find other' s needs oppressive. Lack of warmth lack of interest in other' s wellbeing	Name own needs, and needs of others Curious about therapist' s needs Recognize therapist needs Can show appreciation of therapist Willing to respect therapeutic contract Able to set boundaries with therapist
	8 - PLAY (Learning adaptive and social skills: being in our body, ties in with curiosity & social joy) Works with 6 & 7	Excessive seeking for stimulation, mental and physical, sensitive to boredom as deprivation Engage in hedonistic activities to fill other unmet needs. Lack of curiosity & expression of joy Lack of interest in environment, tune out Stereotypical/ rule following behaviour without flexibility or creativity. Fear of deprivation leads to overwork, experience of joy not important	Excessive use of humour to deflect conflict "don' t take things seriously" Seek short-term hedonic pleasure to counter aversive experiences. Instant gratification Use of sarcasm/humour to express anger Shut down and sluggish, not in touch with body. Afraid to have fun and show joy. Risk averse, reluctant to experiment with new activities or situations. Have to be serious and problem orientated for protection	Creative with activities, Active mental and physical life. Connected with body sensations, coming alive with vitality Physically and mentally explorative, Able to share pleasurable experiences. Can initiate and respond to joy. Can defuse by taking a humorous perspective on problems
Group function: regulating conflict	9 – DOMINANCE / Rank (feeling mastery over environment, controlling aggression in social group and allocation of resources) Works with 3, 4 & 5	Take without considering others, high entitlement Preoccupied with status, by showing or referencing status symbols. Posturing, dominate space Checking therapist status Unwilling to share learning or resources, demanding Invade space, taking over, Lack of entitlement to resources, afraid to take Perceived incompetence, hesitant, self-doubt Submissive, and unable to communicate needs Afraid to take-up room, closed up. Passive and waiting for therapist lead	Trying to control and dominate others, intrusive posturing, invade psychological and physical boundaries Showing weakness feels dangerous Excessive control over events/environment Unable to be vulnerable to accept help Do not listen or notice therapist care/input Stuck in submissive/ passive behaviours Give therapist control for protection/avoid conflict Lack of competence over functioning, helpless	Being in control of self, self-regulation. Recognise and appreciate competence in self and others. Willing to learn and be in control of mastery Internal locus of control, self-control, perseverance and stamina Able to meet needs with effective problem solving. Willing to share learning and resources.

Cutting up

Shamed and gutted

Wild man: what I want I can have

Violent

Scared kid like When I was abused

Paranoid head on

Rejected

Sensible head on

Dominance
System used
To offset
negative affect

Cutting up

Shamed and gutted

Violent

Wild man: what I want I can have

Scared kid like When I was abused

Fear system

Paranoid head on

Attachment
system

Rejected

Sensible head on

Capacity to think
‘back on line’

STATES

Altered states and emotional processes linked with both trauma and offending

- People often describe being traumatised during and after their own offending (e.g Gray et al 2003, Kruppa 1991)
- This is likely to be a combination of triggered past trauma (Moskowitz 2004) and current traumatic situation
- Often in a dissociated state – but also other sates e.g. hypomanic or depressed
- Amnesia is often described by people who have committed a serious offence
- 'it just happened' 'it was as if I was in the back seat watching it' ' felt as if it wasn't me'
- Loss of experience of agency during the course of the offence
- Offence Related Altered States of Consciousness can be significantly different from Normal Waking Consciousness (NWC) and overlaps significantly with Trauma Related Altered States of Consciousness (TRASC)

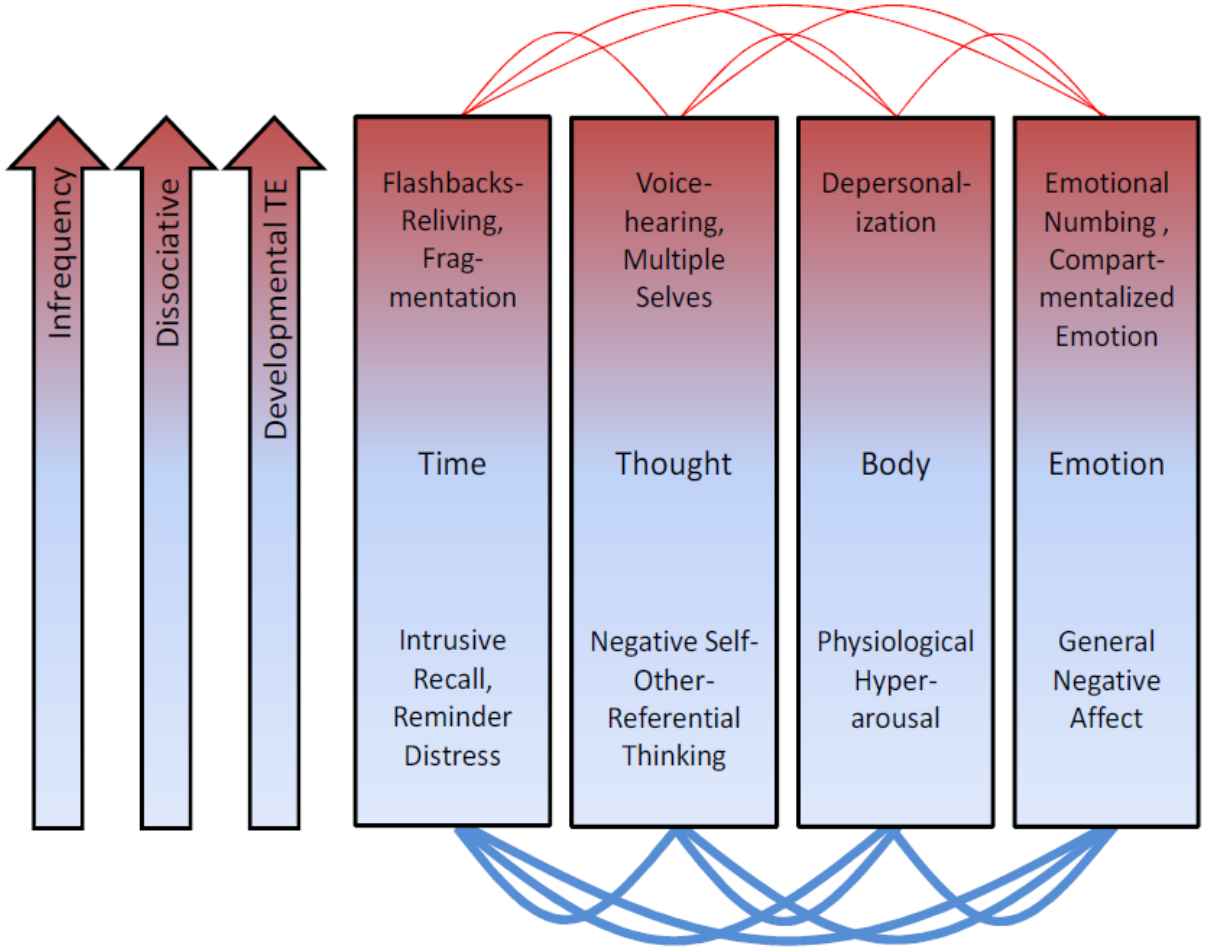


Figure 1. The 4D-Model of Trauma Related Dissociation. NWC symptoms are represented along the bottom of the model in blue, and TRASC symptoms are shown along the top of the model in red. TE = Trauma Exposure. Adapted from "*Healing the Traumatized Self: Consciousness, Neuroscience, Treatment*" by P. A. Frewen and R. A. Lanius, 2014.

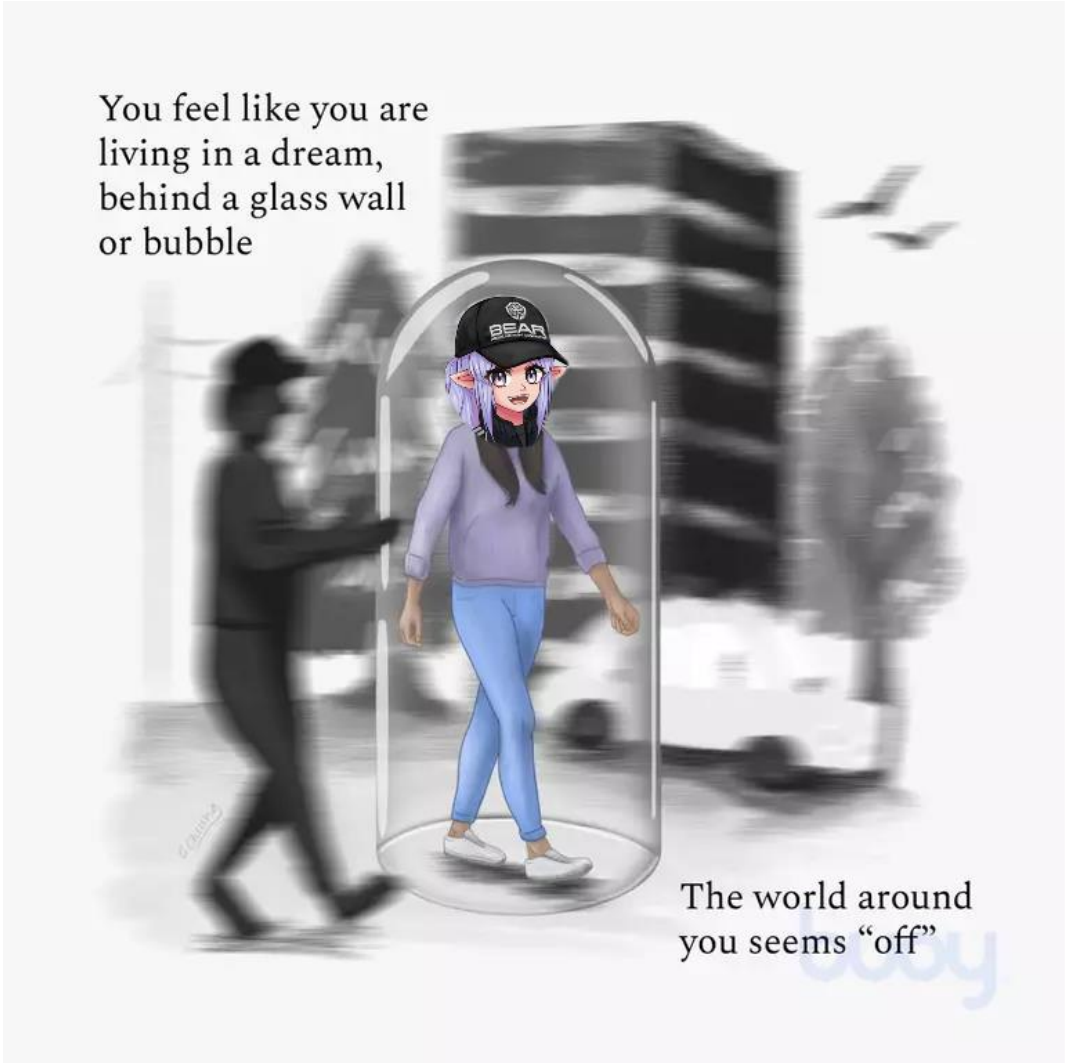
NWC = Normal waking consciousness; TRASC = Trauma related altered states of consciousness

Dr Emma Černis Retweeted

Temp-Tempai @FlavrTemp · Jul 26

Replying to @Sleepy_Proj

You mean like derealization?



States of consciousness, not just Emotion

- Attention
- Capacity to feel (what people aren't feeling as well as what they are)
- Capacity and willingness to think
- Felt intentionality vs Felt intrusiveness of thoughts, emotions and memories
- Trauma and offence related altered states of consciousness
- Similar impact on cognition and consciousness obtained by strong activation of all motivational systems
- Shift in consciousness often follows shift in emotional state (Heekerens et al 2023) transdiagnostic model of dissociation based on the idea that dissociative reactions are affect contingent and serve affect regulation functions (i.e. very adaptive)
- Manic and hypomanic states can serve a similar function
- Trigger > Emotion > Dissociation > Offending themes … exacerbated or controlled by substance use

Altered states like dissociation, depression, hypomania

- Critical to making sense of trauma reactions in the lead up and during offending
- Relevant to developing interventions
- Constriction and intrusion, the “dialectic of trauma.” Herman (1992/2015)
- Lack of feeling in the body, numbness, emotional flatness, anhedonia…
- Often the state that somebody is in when they offend is
- State dependant learning can mean that people don’t employ the skills or different ways of thinking they have developed in the context of therapy
- radically different from that in which they are learning the skills to avoid offending
- Hypomanic states linked with egocentric and impulsive behaviour
- Dissociation and loss of emotional contact can be out of touch with others’ feelings
- In altered state access to empathy can be absent
- Motz ‘Intoxicating states of mind’

Sexual dissociation

- Useful to formulate the impact of sexual abuse on individuals' sexual experiences
- E..g. avoid sex, preoccupied with sex, sexual difficulties, various forms of stat constriction or intrusion linked with sexual arousal
- Relevant to sexual and violent offending as well as part of trauma intervention
- Post-Traumatic Sexuality (PT-SEX) Scale (Ateret et al 2022) looks at dissociation during sex, intrusiveness during sex, shame and guilt in regard to sexual aspects, pleasing the other during sex, interpersonal distress, and hypervigilance during sex

Dissociation informed care (Pierorazio & Brand 2022)

Argue for trauma and dissociation informed care

States of attachment; all linked with different states

- being alone;
- seeking relationship;
- being rejected (exclusion pain, Baumeister);
- forming a relationship;
- having a honeymoon period;
- maintaining a relationship;
- reacting to separations (brief and protracted);
- reacting to reunion following separation;
- becoming estranged within a relationship;
- ending a relationship;
- having a partner end a relationship;
- being faithful or unfaithful;
- experiencing a partner being faithful or unfaithful (jealousy); and
- coping with children and significant others in own and partner's life.

Betrayal trauma, Moral injury

The importance of context

- and the re-traumatising or exposure to ongoing trauma that is typical of post release settings (I used to work in a hostel for ‘ex offenders’, so have a strong sense of the kinds of traumatising and deprived contexts people are expected to not reoffend in)

Cultural and oppressive experiences that link with trauma

- not “don’t ask me what’s wrong with me ask me what happened to me”, but “don’t ask me what’s wrong with me ask me what happened to me and my people”
- Quiros et al 2020 Argue that historically trauma literature and therapies neglected to attend to the unique needs pf people from minoritised groups – focussing particularly people who have experienced racism
- Highlight the cumulative impact of experiences of oppression

Formulating power

- What is power?
- What is the impact of having different kinds of power on the propensity to objectify other people?
- In forensic settings we are interested in the impact of powerlessness experiences on people's interest/capacity/propensity to exert power over others in ways that deny their humanity
- Why does power misuse sometimes result as a consequence of trauma and adversity?
- Johnson et al (2012) Dominance system
- Owen et al (2008) Experiences of power resulting in a kind of 'addiction' …'they hubris syndrome
- Young et al (2003) Schema therapy power misuse as a 'protective' schema compensation for powerlessness experiences
- Schwartz & Sweezy (2020) IFS Power misuse as a form of 'protector' and 'firefighter'
- Ryle (1997) Power misuse as the almost obligatory flip side of any experience of powerlessness

abusing to abused, controlling to controlled. Has the implication that all abuse can result in the internalisation of a propensity to 'identify with the abuser' (an idea developed originally by Ferenczi)

Mortality and beliefs about death and dying

- Common theme in trauma work is the experiences people have of being overwhelmed in different ways and how these are experienced as a threat to life
- People then are thrown into their beliefs about death
  - Heaven Hell
  - Painful death
  - Horror and terror
- Terror management theory useful in thinking about the ways in which these fears – amplified by trauma experiences – get played out in the individual
- Power related behaviour can come out of a sense of futurelessness (Kerig)

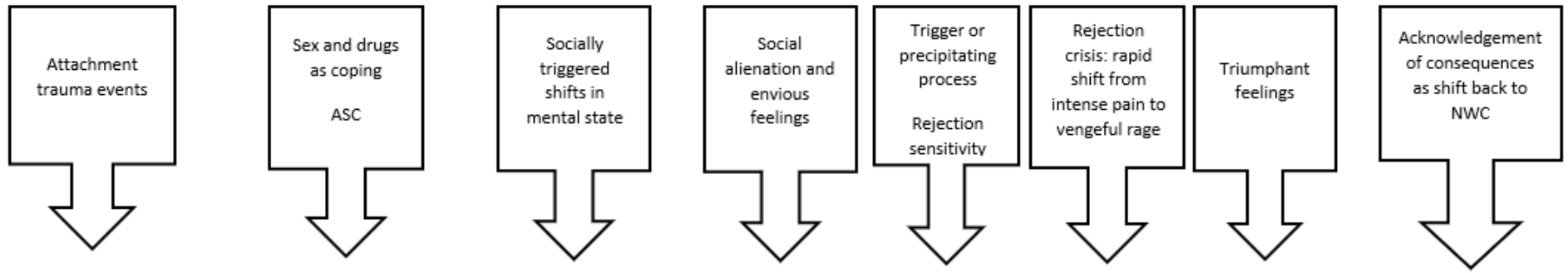
  that can then result in not taking others into account
- If you do the thought experiment answering the question: In what contexts might I kill somebody or harm somebody … it is not uncommon for people to say that it is in contexts where their lives are threatened
- Often beliefs change in different states

Forensic formulations are about events – offences – as well as ‘pervasive’ distress of different kinds

- Sequential understanding of the development of the offence becomes important in this context
- Intervention is about preventing processes and sequences

Incident	Age	Relationship ending	Substance misuse and using pornography to manage hurt	Prolonged Isolation avoiding contact	Envious and "looking in"	Interprets being 'rebuffed' as rejection	Attacks stranger	Reports revenge satisfied	Escapes Fears getting caught Feelings of shame and guilt
Attempted rape and violent assault	36	Split up with partner after assaulting them whilst fearing rejection and became increasingly isolated	Reports that he was using drink, drugs and pornography to kill pain	Increasingly experienced self as being 'in a bubble' and cut off from people	Says he was "watching from the outside"	Seeks to meet somebody in a bar and is rebuffed becomes angry and rejection is triggered	Attempts to rape stranger	Reports sense of satisfaction about what happened initially	Attempted to use DES and later experienced both shame and fears of getting caught
Violent assault	25	Working away from home. Partner is at home. Begins to express feelings of jealousy towards her.	Increased use of drink drugs and pornography	Works hard and becomes increasingly cut off from others	Feels his colleagues are talking about him and does not feel part of the team	Told he must work on a Friday night; feels picked on and rejected by his manager	Goes into town the next day and gets into an argument and assaults shop attendant	No account of how he felt	Lies to police saying that he had been assaulted first. Retrospectively reports feelings of shame and fears of getting charged.

Table 7 Psychological processes at different stages of offence and developmental antecedents



Incident	**Age**	**Relationship ending**	**Substance misuse and using pornography to manage hurt**	**Prolonged Isolation avoiding contact**	**Envious and "looking in"**	**Interprets being 'rebuffed' as rejection**	**Attacks stranger**	**Reports revenge satisfied**	**Escapes** **Fears getting caught** **Feelings of shame and guilt**
Childhood conduct difficulties	7	Taken into care after accounts of being assaulted by both parents	Reports of sexual behaviour with peers in care setting. Also reports of episodes of early experimentation with alcohol	Increasingly experienced self as being 'a loner' in care. Also angry about lost family and being abandoned by parents	Episode where he stole from fellow pupils at school. Reported that he was jealous of what they had	Seeks friendships at school but then reacts badly when he believes that he is being rejected or unwanted.	Fights at school	Reports of feeling good about attacking people and expressing revenge	Attempted to use DES and felt shame about his behaviour and 'not being like other people'

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Outside after release	39	Forms new relationship and she reports that he has become very 'possessive' and threatening at times. Relationship comes to an end.	Tells probation officer that he had been drinking heavily and reports using pornography	Stays at home stops going out to look for work, slowly does less and less	Reports feeling like an outsider	Attempts to form a relationship with somebody he had met in gym, but they do not want this	Visits former partner and threatens her with assault	Reports that this was a release of pent up emotion	Begs her not to tell probation or police that he has done this. Experiences shame and fear of recall
Offence paralleling context after release		Hostel staff or probation staff do not have the trauma informed perspective to enable them to recognise crisis and support/scaffold coping with ongoing racism and adversity.	Lack of resources needed to help manage emotional distress e.g. support, activity scheduling, employment, leisure activity.	Neglect from staff who could have recognised the pattern and supported the individual to get through it. Lack of trauma awareness.	Lack of social capital and opportunities to feel as if belongs. Lack of understanding of the significance of connection or lack of it	No alternative relationships. No space to work on what has been triggered both by current rejection and past rejection and exposure to racism, homophobia, sexism etc	Lack of monitoring.		Lack of support and trusting relationships

Idiogrid software idiogrid.com

TABLE 8.1 Elements used by James

Self elements:	**Family elements:**
Me as victim 1 (self as victim of babysitter)	Mum
Me as victim 2 (self as victim of abuse by mother's relative)	Mum not believing
As I'd like to be	Dad
Me offending	Granny
Me now	John (brother)
Victim elements:	**Significant other elements:**
Victim of the offence	Jane (ex-girlfriend)
Mother's friend who abused me	Pete (staff member)
Babysitter who abused me	Andrew (friend)

TABLE 8.2 Constructs used by James

Lazy, didn't want to help	–	Wanted to be a provider
Bully, rebel	–	Understands and cares
Dismissing	–	Respects you
Always wanting revenge	–	Happy, wants a laugh
Not able to change	–	Learn by looking
Coward runs away	–	Stands up to people
Hates everyone	–	A person who likes people
Open-minded about sex	–	Frightened of sex
Upbeat, straightforward, confident	–	Not confident, scared of sex
No cares	–	Full of shame
Concerned about others	–	Doesn't care, dangerous, self-centred
Very contented	–	Terrified, easily taken advantage of
No love, live in terror, unhappy	–	Genuinely loving
Will try anything	–	Sexually inhibited
Lost innocence wanting to be rescued	–	Doing childish things happily
Outward going, giving, helps people	–	Very wicked and not worried about this
Helps people, concerned about others	–	A brute trying to hurt people
Strong and fearless	–	Extremely frightened

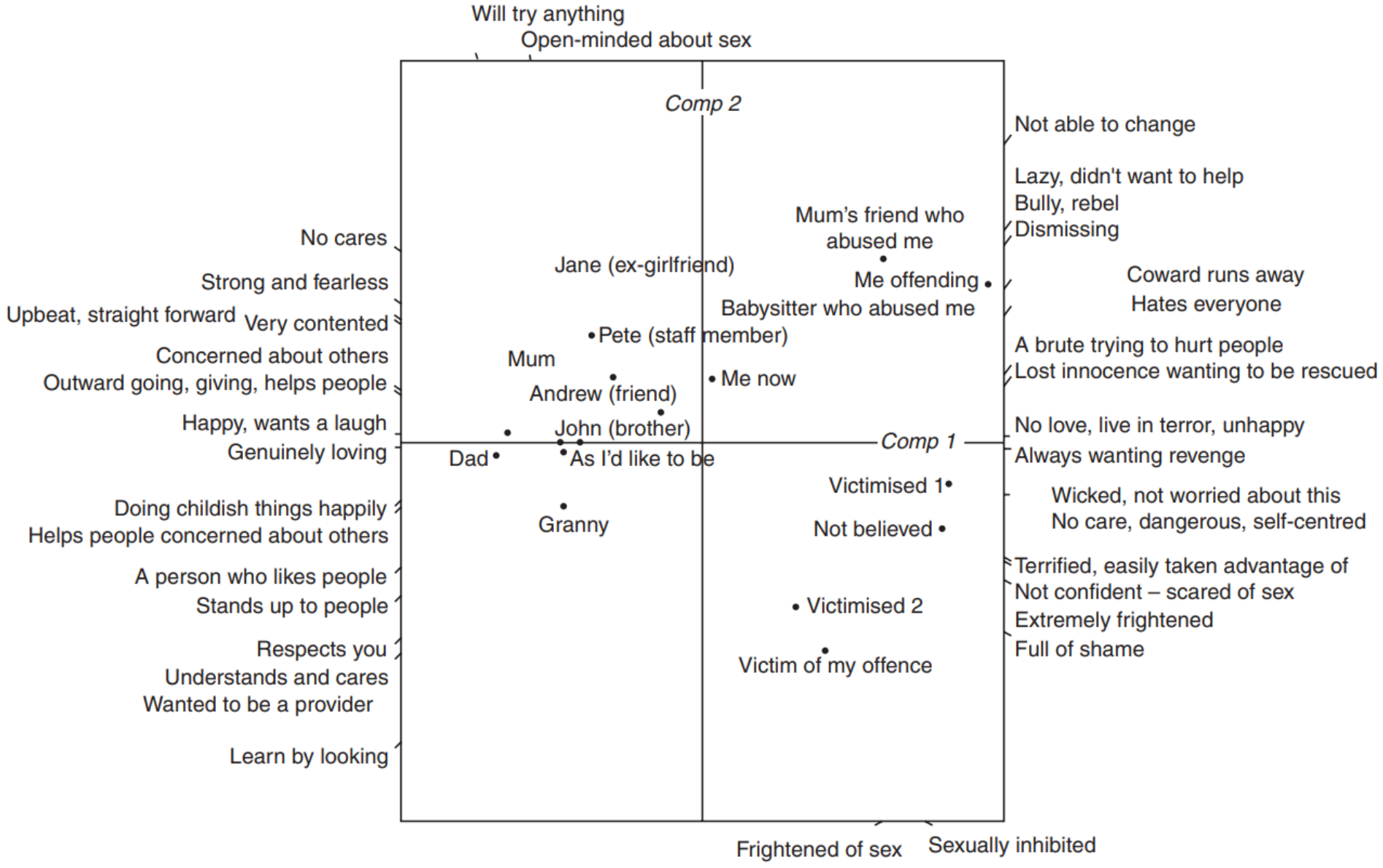
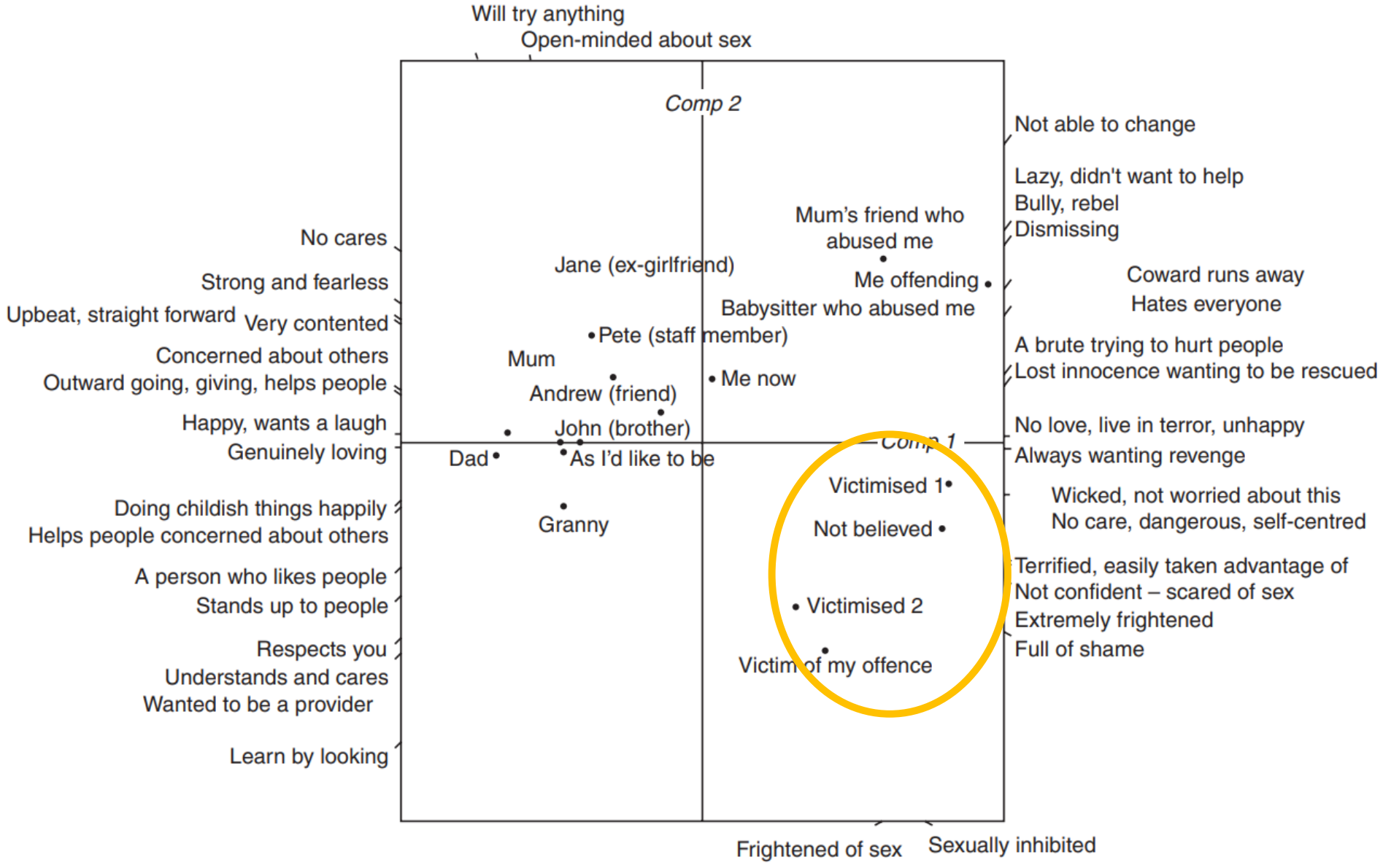


FIGURE 8.1: Principal component analysis of construing of self and other people, incorporating aspects relevant to offending and experiences of abuse.



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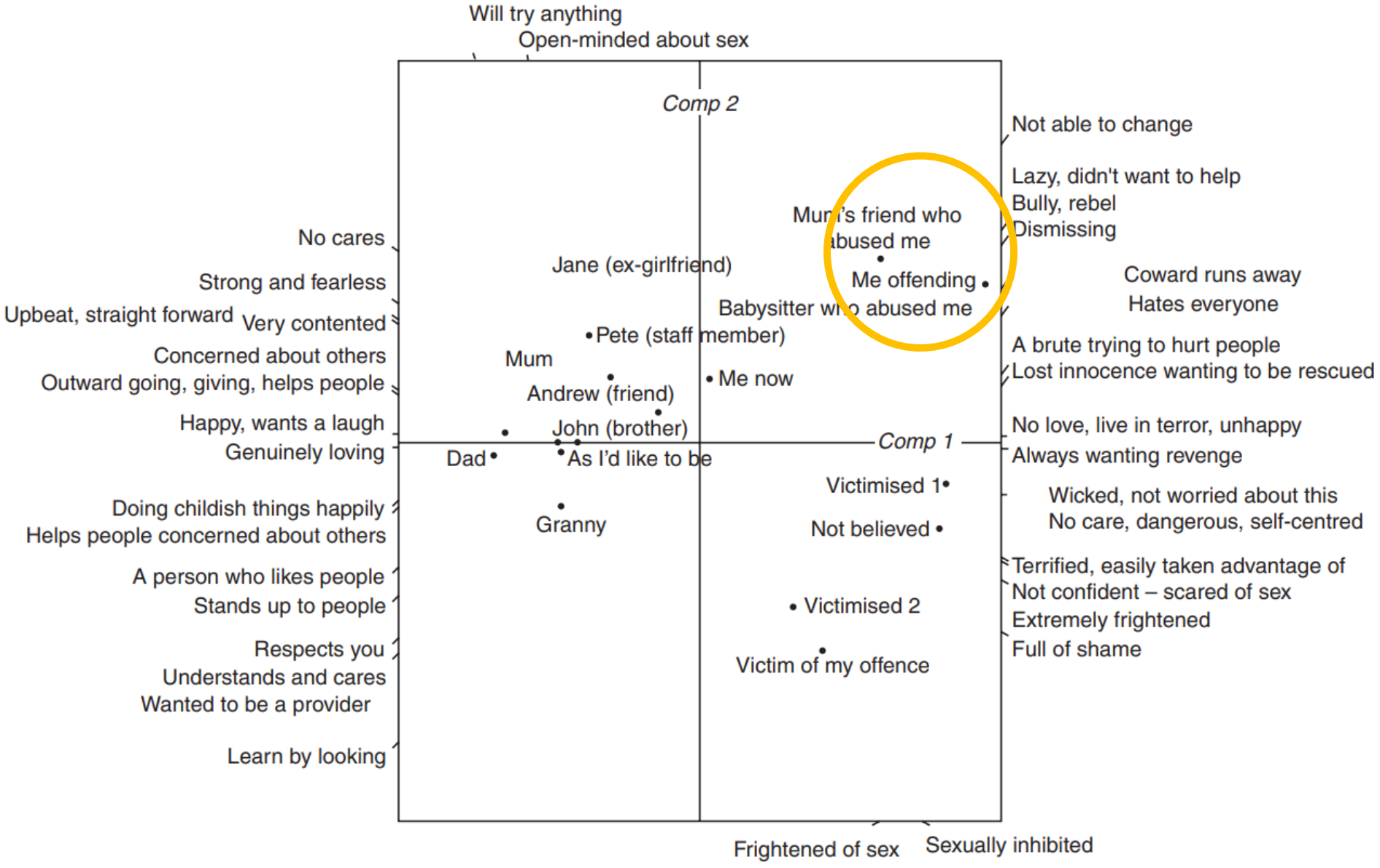

FIGURE 8.1: Principal component analysis of construing of self and other people, incorporating aspects relevant to offending and experiences of abuse.

Final thoughts

- Formulation needs to link to interventions
- They are interventions in themselves however
- Humility and co-curiosity are critical
- Different kinds of formulations suit different kinds of intervention
- Need to keep them simple and accessible
- Need to test formulations, hypotheses are tentative